Agency Name: _____

San Francisco ONE System: HHS-PATH PROJECT EXIT FORM
Use block letters for text and bubble in the appropriate circles.
Please complete a separate form for each household member.

CLIENT NAME OR IDENTIFIER *:_____*

PROJECT EXIT DATE *[All Clients]*

		-			-			

     Month   Day   Year

CLIENT LOCATION *[only if multiple CoC's]* _____

DESTINATION *[All Clients]*

○	Deceased	○	Rental by client, with RRH or equivalent subsidy
○	Emergency shelter, including hotel or motel paid for with emergency shelter voucher	○	Rental by client, with VASH housing subsidy
○	Foster care home or foster care group home	○	Rental by client, with GPD TIP housing subsidy
○	Hospital or other residential non-psychiatric medical facility	○	Rental by client, with other ongoing housing subsidy
○	Hotel or motel paid for without emergency shelter voucher	○	Residential project or halfway house with no homeless criteria
○	Jail, prison or juvenile detention facility	○	Safe Haven
○	Long-term care facility or nursing home	○	Staying or living with family, permanent tenure
○	Moved from one HOPWA funded project to HOPWA PH	○	Staying or living with family, temporary tenure (e.g., room, apartment or house)
○	Moved from one HOPWA funded project to HOPWA TH	○	Staying or living with friends, permanent tenure
○	Owned by client, no ongoing housing subsidy	○	Staying or living with friends, temporary tenure (e.g., room, apartment or house)
○	Owned by client, with ongoing housing subsidy	○	Substance abuse treatment facility or detox center
○	Permanent housing (other than RRH) for formerly homeless persons	○	Transitional housing for homeless persons (including homeless youth)
○	Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/airport or anywhere outside)	○	Other (specify):
		○	No exit interview completed

○	Psychiatric hospital or other psychiatric facility	○	Client doesn't know
		○	Client refused
○	Rental by client, no ongoing housing subsidy	○	Data not collected

PATH STATUS [If not at intake]

Client Became Enrolled in PATH	○	No
	○	Yes
Date of Status Determination	_____/_____/_____	
IF "NO" TO ENROLLED IN PATH		
Reason Not Enrolled	○	Client was found ineligible for PATH
	○	Client was not enrolled for other reason(s)

CONNECTION WITH SOAR [Heads of Households and Adults]

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

DISABLING CONDITION [All Clients – if 'yes' to any condition, mark 'yes']

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

PHYSICAL DISABILITY [All Clients]

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

IF "YES" TO PHYSICAL DISABILITY – SPECIFY					
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○	No	○	Client doesn't know
	○	Yes	○	Client refused
			○	Data not collected

DEVELOPMENTAL DISABILITY [All Clients]

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

IF "YES" TO DEVELOPMENTAL DISABILITY – SPECIFY					
Expected to substantially impair ability to live independently?	○	No	○	Client doesn't know
	○	Yes	○	Client refused
			○	Data not collected

CHRONIC HEALTH CONDITION *[All Clients]*

O	No	O	Client doesn't know
O	Yes	O	Client refused
		O	Data not collected

IF "YES" TO CHRONIC HEALTH CONDITION – SPECIFY

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	O	No	O	Client doesn't know
	O	Yes	O	Client refused
			O	Data not collected

HIV-AIDS *[All Clients]*

O	No	O	Client doesn't know
O	Yes	O	Client refused
		O	Data not collected

IF "YES" TO HIV-AIDS – SPECIFY

Expected to substantially impair ability to live independently?	O	No	O	Client doesn't know
	O	Yes	O	Client refused
			O	Data not collected

MENTAL HEALTH PROBLEM *[All Clients]*

O	No	O	Client doesn't know
O	Yes	O	Client refused
		O	Data not collected

IF "YES" TO MENTAL HEALTH PROBLEMS – SPECIFY

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	O	No	O	Client doesn't know
	O	Yes	O	Client refused
			O	Data not collected

SUBSTANCE ABUSE PROBLEM *[All Clients]*

O	No	O	Both alcohol & drug abuse
O	Alcohol abuse	O	Client doesn't know
		O	Client refused
O	Drug abuse	O	Data not collected

IF "ALCOHOL ABUSE" "DRUG ABUSE" OR "BOTH ALCOHOL AND DRUG ABUSE"– SPECIFY

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	O	No	O	Client doesn't know
	O	Yes	O	Client refused
			O	Data not collected

INCOME FROM ANY SOURCE *[Head of Households and Adults]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY

Income Source		Amount	Income Source		Amount
○	Alimony and Other Spousal Support		○	Child support	
○	Pension or Retirement income from former job		○	Earned Income	
○	Retirement Income from Social Security		○	CAAP	
○	Social Security Disability Insurance (SSDI)		○	Private Disability Insurance	
○	Supplemental Security Income (SSI)		○	Unemployment Insurance	
○	CalWORKs		○	Worker's Compensation	
○	VA Service Connected Disability Compensation		○	Other source	
○	VA Non-Service Connected Disability Pension		Other (specify):		
Total monthly amount:					

RECEIVING NONCASH BENEFITS *[Head of Household and Adults]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

IF "YES" TO NONCASH BENEFITS – INDICATE ALL SOURCES THAT APPLY

○	CalFresh	○	CalWORKs Childcare Services
○	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	○	CalWORKs Transportation Services
○	Other (specify):	○	CalWORKs TANF-funded services

COVERED BY HEALTH INSURANCE *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

IF "YES" TO HEALTH INSURANCE HEALTH INSURANCE COVERAGE DETAILS

○	Medi-Cal	○	Employer Provided Health Insurance
○	MEDICARE	○	Insurance Obtained through COBRA

○	State Children's Health Insurance (SCHIP)	○	Private Pay Health Insurance
○	Veteran's Administration (VA) Medical Services	○	State Health Insurance for Adults
○	Other (specify):	○	Indian Health Services Program

CONTACT INFORMATION

Contact Type:				
Email:				
Phone (#1):				
Phone (#2):				
Active Contact:	○	**Yes**	○	**No**
Private:	○	**Yes**	○	**No**
Contact Date:				
Note:				

_____

Signature of applicant stating all information is true and correct   **Date**